INTRODUCTION

- The following presentation describes the design and content of the VA. State Vaccination Campaign Plan Seminar and Tabletop Exercise. Emphasis is required to illustrate that this was a State-Level Series to Roll-Out the State Vaccination Campaign Plan and to exercise the State's ability to operationalize and implement. VDH has designed guidance and a plan template for use at the Local Health District (LHD) Level.
- Additionally, a ***TABLETOP-IN-A-BOX*** Exercise is forthcoming, also for use at the LHD level.
- Our VDEM partners have asked that we include the following for consideration at the local EM level: "There are several types of resources that may be necessary to successfully conduct COVID Vaccination Point of Dispensing (POD). Items to consider include (but are not limited to) tents, tables, chairs, internet access, generators, fuel, electric cords, etc. If these items, or others, are needed, local health directors will need to coordinate with the local emergency manager as well as VDH / VDEM regional personnel.

Virginia COVID-19 Vaccination Tabletop Exercise

Virginia Department of Health (VDH)

Oct 14, 2020

Vaccinations Seminar & Tabletop Overview

Thu, 10/8,
8:00a-2:00p

COVID-19 Vaccination Plan Seminar

Focus:
- *Foundational understanding of the current COVID-19 Vaccination Plan*

TODAY: Wed, 10/14,
8:00a-2:00p

COVID-19 Vaccination Plan Tabletop Exercise

Focus:
- "Red team" exercises to identify (1) gaps in the current Plan and (2) opportunities to improve Plan execution

Outbriefs:

Oct. - Secure Commonwealth panel (written)

Nov. - Health & Medical sub-panel

Focus:
- Brief Cabinet-level leaders on outputs of the exercises, and provide advanced notice of anticipated requests for leadership support

IMPORTANT NOTE: Given the evolving nature of the COVID-19 vaccine environment and Virginia's drafted vaccination plan, today's exercise is **not** a traditional tabletop exercise.

Rather than a full walk through of the Plan, success for today entails identifying risks to the Plan's execution, identifying specific opportunities to strengthen the Plan, and building inter-agency connections.

Outline of Today

Topic/Activity	Presenter
Welcome & Overview	Sebastian Little Bob Mauskapf
COVID-19 Vaccination Strategy, Planning Assumptions, Known Gaps, and Decision Briefs	Michael Magner, Jonathan Kiser
Vaccinations Campaign – Our Mission	Marshall Vogt
Breakout Group 1: Identify Risks	Multiple VDH, VDEM, and McChrystal facilitators
Debrief Breakout Group Discussions	Jeff Eggers
Breakout Group 2: Manage Risks	Multiple VDH, VDEM, and McChrystal facilitators
Debrief Breakout Group Discussions	Jeff Eggers
Next Steps & Closing Comments	Bob Mauskapf Curtis Brown, Dr. Oliver

Breaks, including 30 minutes for lunch, will be provided throughout the day.

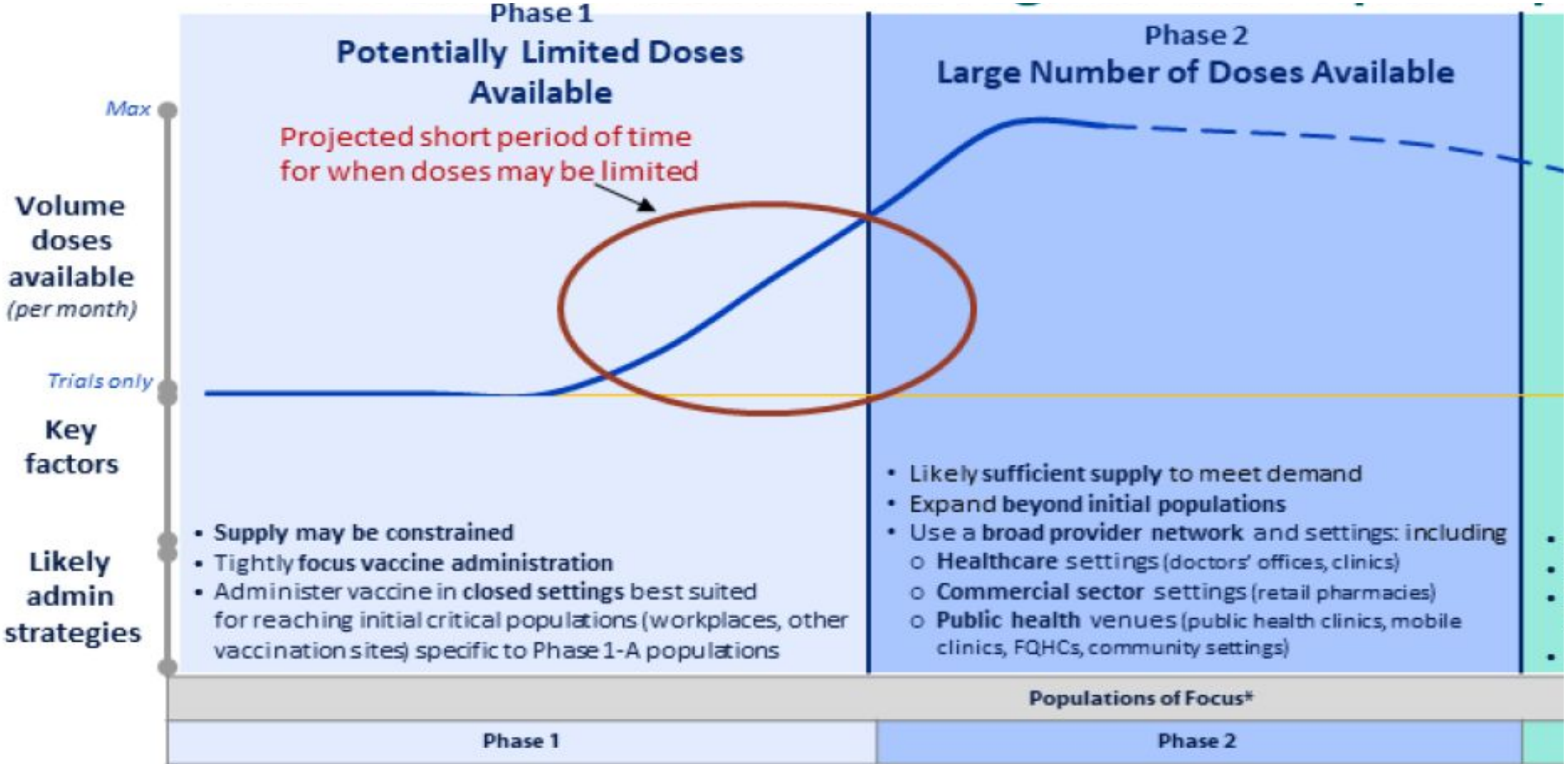
OPENING REMARKS

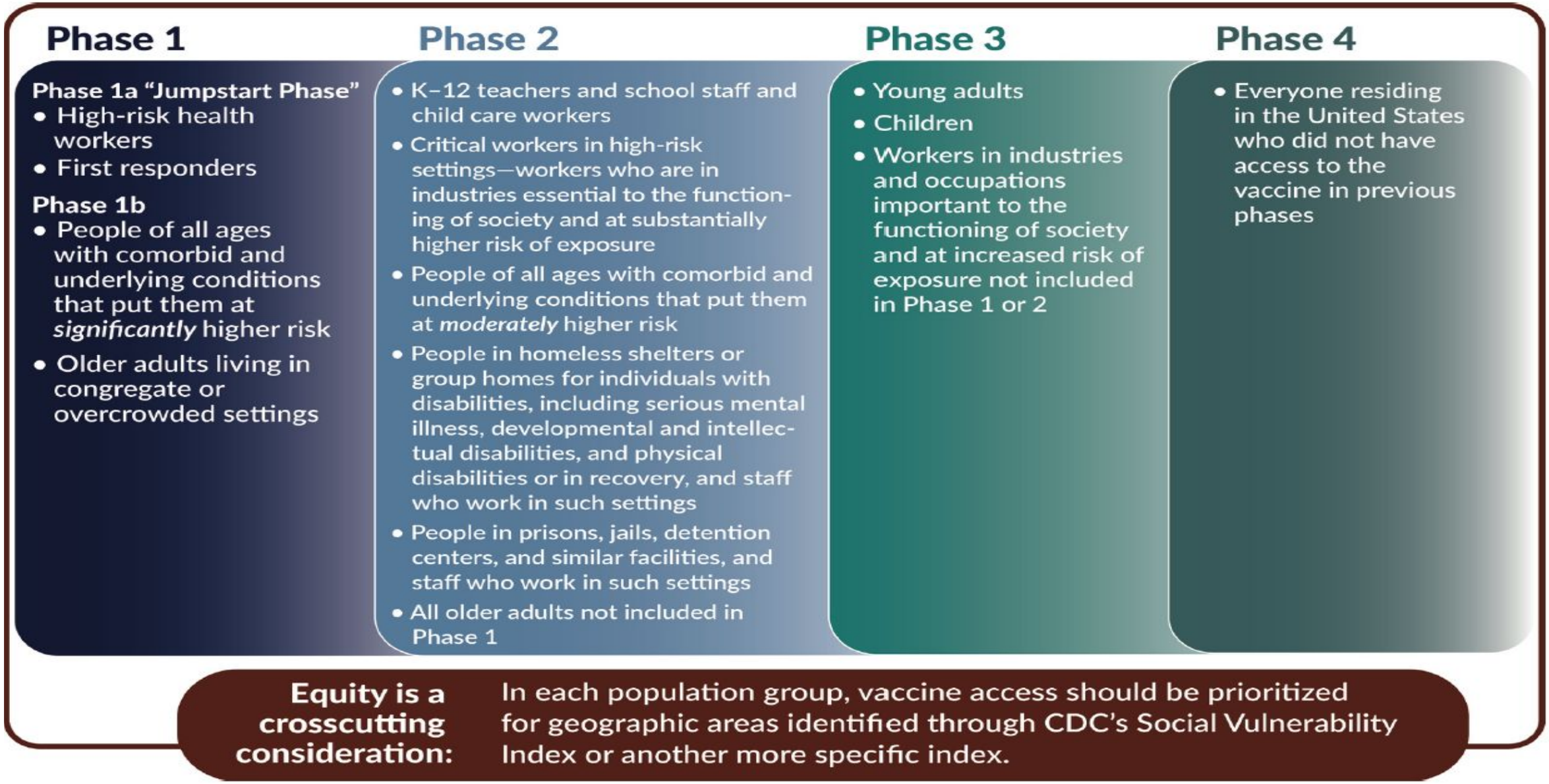
BOB MAUSKAPF, DIRECTOR OF EMERGENCY PREPAREDNESS

COVID-19 VACCINATION STRATEGY, PLANNING ASSUMPTIONS, KNOWN GAPS & DECISION BRIEFS

MIKE MAGNER, CENTRAL REGION EMERGENCY COORDINATOR
JONATHAN KISER, STATE PLANNING AND SNS COORDINATOR

Virginia's COVID-19 Vaccine Strategy based on CDC guidance





National Academies of Science, Engineering and Medicine's Vaccination Priority Group Recommendations

Source: [The National Academies Press, Framework for Equitable Allocation of COVID-19 Vaccine (2020)]

Key Planning Assumptions

- Limited COVID-19 vaccine doses may be available by early November 2020, but assuming a safe, effective vaccine(s) is developed, COVID-19 vaccine supply will increase substantially in 2021.

- Initially available COVID-19 vaccines will either be approved as licensed vaccines or authorized for use under an Emergency Use Authorization (EUA) issued by the U.S. Food and Drug Administration (FDA).

- For most vaccines, two doses of COVID-19 vaccine, separated by either >21 or >28 days, will be needed for immunity, and second-dose reminders for patients will be necessary. Both doses will need to match each other (i.e., be the same vaccine product).

Key Planning Assumptions (cont.)

- The federal government will issue guidance on groups to prioritize for initial COVID-19 vaccination. Populations of focus for initial COVID-19 vaccination will likely be:
  - Critical workforce that provides healthcare and maintains essential functions of society
  - Staff and residents in long-term care and assisted living facilities

- To receive and administer COVID-19 vaccine and ancillary supplies, vaccination providers must enroll in the United States Government (USG) COVID-19 vaccination program, coordinated through the VDH Division of Immunization.
  - **NOTE: information systems are not the focus of today's exercise.** For today, we can assume necessary providers will be enrolled and understand how to use the systems

Key Planning Assumptions (cont.)

- COVID-19 vaccine and ancillary supplies will be procured and distributed by the federal government at no cost to enrolled COVID-19 vaccination providers.
- Ancillary supply kits will include needles, syringes, alcohol prep pads, COVID-19 vaccination record cards for each vaccine recipient, and a minimal supply of PPE, including surgical masks and face shields, for vaccinators.
  - Each kit will include supplies needed to administer 100 doses of vaccine.
  - For COVID-19 vaccines that require reconstitution with diluent or mixing adjuvant at the point of administration, separate mixing kits will include additional necessary syringes, needles, and other supplies for this purpose.
  - Sharps containers, gloves, bandages, and other supplies **will not be included**.
  - Ancillary kits will ship to coincide or arrive just before shipments of vaccine.

Key Planning Assumptions (cont.)

- Additional PPE will be needed, and demand will vary based on vaccination site.
  - Unified Command has approved a funding request to support PPE for public health vaccination efforts. This PPE will be provided through the existing PPE distribution model.

- Additional resource needs include:
  - Equipment
  - Ancillary Supplies
  - Local Health District PODs
  - Warehousing and Shipping
  - Communications Campaign

During initial planning, VDH identified the following gaps in Virginia's current ability to execute a COVID-19 Vaccination Plan

Equipment

- Funding to support purchase of vaccine refrigerators & freezers, portable units, etc.

Ancillary Support

- Funding to purchase needed ancillary supplies

Info Management Staffing

- Funding for temporary positions who will develop & maintain ".net" apps

Pharmacy Benefits Administrator

- Funding for PBA to manage claims for un- and under-insured Virginias & to pay other providers

Mass Vaccination Support for Local Health Districts

- Funding to cover operating costs for clinics

Warehousing + Shipping

- Funding to support warehousing + shipping of ancillary supplies

Communication Campaign

- Funding to support public education campaign & targeted outreach to key groups

Planning Gaps

- Need Districts to update Point of Dispensing (POD) and Closed POD (CPOD) plans to comply with CDC guidance

QUESTIONS & ANSWERS:

COVID-19 VACCINATION STRATEGY, PLANNING ASSUMPTIONS, KNOWN GAPS, AND DECISION BRIEFS

BREAK

PLEASE RETURN AT 8:54

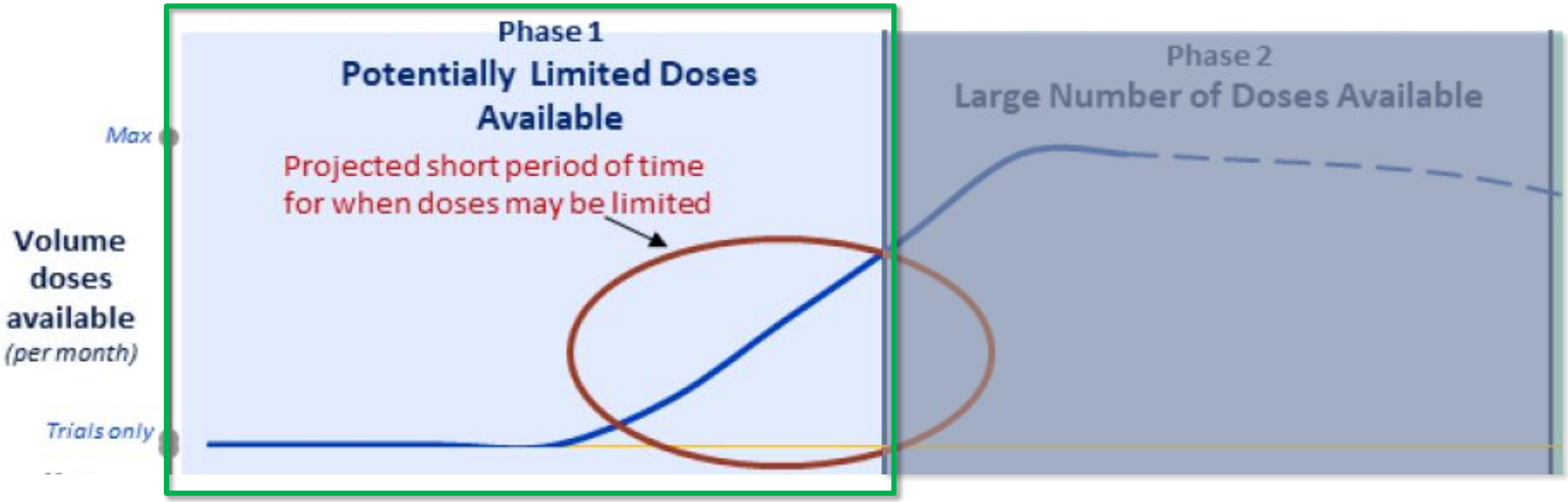
COVID-19 VACCINATIONS CAMPAIGN: OUR MISSION

MARSHALL VOGT, DIVISION EPIDEMIOLOGIST

IMPORTANT NOTES:

- The following slides provide estimates for the coming months based on CDC guidance.
- Details (e.g., dates, vaccines, quantities, etc.) are not exact and are subject to change.

Vaccine Supply Expected to Increase Rapidly in Coming Months



Nov '20 – Jan '21: Limited vaccine doses available

- Highly targeted campaign to immunize critical infrastructure workforce & persons with the highest risk of severe illness
- Most vaccination events will be Closed Point of Dispensing (CPOD) events for specific groups.
- Public communications emphasize the need to prioritize limited supplies for critical populations while assuring the general public additional vaccine supplies are on the way soon.

The initial vaccine supply is expected to be available in 2020

EUA Vaccine A availability to VA*:

End of Nov '20:
~300,000 doses
(~150,000 people)

End of Dec '20:
~500,000 doses
(~250,000 people)

End of Jan '21:
~500,000 doses
(~250,000 people)

* Estimates based on jurisdictional planning scenario in CDC Playbook and VA population size

Vaccine A

SHIPMENT

3 separately acquired components (mixed on site)

1. Vaccine
   - Direct to site from manufacturer (on dry ice)
   - Multidose vials (5 doses/vial)
2. Diluent
   - Direct to site from the US Government (USG) at room temperature)
3. Ancillary supply kits (for administration and mixing)
   - Direct to site from USG (at room temperature)

ON-SITE VACCINE STORAGE

Frozen (-70 °C ± 10 °C)

- Must be used/recharged within 10 days
- Storage in shipping container OK (replenish dry ice within 24 hours of receiving shipment and again 5 days later)

Thawed but NOT reconstituted (2–8 °C)

- Must use within 5 days (discard unused doses after 5 days)

Reconstituted (room temperature)

- Must use within 6 hours (discard any unused, reconstituted vaccine after 6 hours)

ORDERS

Large quantities, to large administration sites only

- Minimum order: ~1,000 doses
- Maximum order: ~5,000 doses

ADMINISTRATION

2-dose series (21 days between doses)

- On-site mixing required; reconstitute with diluent just prior to administration
- Administer by intramuscular (IM) injection

INITIAL POPULATIONS OF FOCUS AND ANTICIPATED VACCINE ADMINISTRATION SITES

Healthcare personnel — public health, closed point of dispensing (POD), temporary/off-site vaccination clinics + potential for mobile clinics

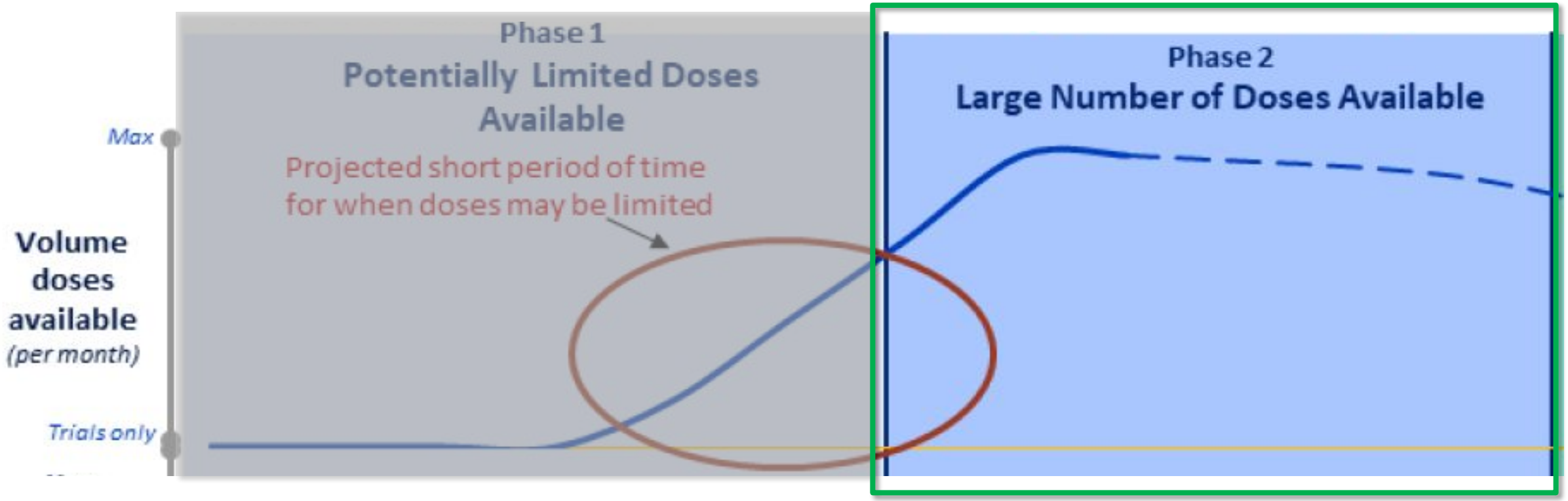
Other essential workers — public health, closed POD, temporary/off-site vaccination clinics + potential for mobile clinics

People at higher risk of severe COVID-19 illness — potential for mobile clinics to long-term care facilities (LTCFs)

CDC recommends jurisdictions also consider the following for early vaccination efforts

- "Healthcare personnel" includes paid or unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to people with COVID-19 or infectious materials.
- Jurisdictions should plan for real-time shipment of doses.
- Administration sites (during Phase 1) will not be required to store vaccine products beyond the period of time Vaccine A can be stored in the ultra-cold shipment box.
- Given the challenging storage, handling, and administration requirements, early vaccination should focus on administration sites that can reach critical populations with as much throughput as possible.
- Stability testing is ongoing for Vaccine A; the storage and handling requirements presented here may shift. The requirements in these scenarios are likely the strictest set of requirements for which planning is needed.

As the number of vaccines and available doses increase, broader populations will be vaccinated



As the number of vaccines, available doses, & target populations **increase, so does the complexity of our mission**

Key Considerations

(many of which are currently unknown and likely to vary)

Allocation:

- Decisions about which vaccine and how much to send are made by CDC

Vaccine Shipment:

- Vaccines will be shipped direct to the Provider, either from the distributor (McKesson) or manufacturer
- Order size will vary by vaccine (e.g., min. of 100 to min. of 1,000)

Vaccine Storage:

- Storage requirements will vary in method (ultra-cold, frozen, refrigerated) and duration (weeks, days, hours) by vaccine

Ancillary Supplies:

- Certain supplies will be shipped direct to the Providers from the US Government (see planning assumptions)
- Additional ancillary supplies will need to be procured, stored, and shipped by VA

Target Populations for Vaccination:

- Begin transition from critical populations to the general public, with assistance from commercial and private sector partners
- Public Health events held to focus on underserved and hard to reach populations
- Large, open/community PODs and mobile vaccination events held

Administration:

- Considerations include number of doses required, days between doses, injection method, and whether diluent is needed
- POD sites must be universally accessible

Communications:

- Messaging needs to simultaneously focus on:
  - encouraging all Virginians to get vaccinated,
  - including appropriate targeted messaging for specific demographics (i.e., race, ethnicity, age, etc.), and
  - countering anti-vaccine narratives

Breakout Groups: Rules of Engagement

A. Vaccine Dispensing Meghan Bourne, Jonathan Kiser	C. Logistics Pavlina Plasilova, Jason Eaton	E. Comms & Outreach Sebastian Little, Lauren Opett
B. Vaccine Dispensing Jeff Eggers, Mike Magner	D. Logistics Billy Don Farris, Bob Mauskapf	F. Comms & Outreach Todd Sanders, Lorrie Andrew-Spear

- Speak up – we have a diverse group of perspectives and we want to hear them all
- Utilize the chat function to add context and ask questions; be prepared to share verbally if a co-facilitator asks you to share with the group
- Refer any questions to your facilitator(s)

Observation Gallery Notes

- You will remain in this large, virtual room for the next 50 minutes, and may use the time as desired
- Breakout group questions are provided on screen for your review/consideration
- During the large group debriefs, we encourage you to ask questions and share insights

Breakout Groups – Round 1:
Identify Risks to Execution of the Draft COVID-19 Vaccination Plan

For the assigned focus area, each group discusses the following:

- How could the Plan fail in the early months when limited doses are available?
- How could the Plan fail once vaccine supply and the mission's complexity increases?
- Which 2 risks/needs identified would you prioritize?

BREAK

PLEASE RETURN AT 10:20

How could the Plan fail in the early months when limited doses are available?

Team A

How could the Plan fail once vaccine supply and the mission's complexity increases?

Team A

How could the Plan fail?

Team B

Limited Supply

Increased Supply

How could the Plan fail in the early months when limited doses are available?

Team C

How could the Plan fail once vaccine supply and the mission's complexity increases?

Team C

How could the Plan fail in the early months when limited doses are available?

Team D

How could the Plan fail once vaccine supply and the mission's complexity increases?

Team D

I. How could the Plan fail in the early months when limited doses are available?

II. How could the Plan fail once vaccine supply and the mission's complexity increases?

Team E

Team F

I. How could the Plan fail in the early months when limited doses are available?

II. How could the Plan fail once vaccine supply and the mission's complexity increases?

BREAK

PLEASE RETURN AT 11:13

Breakout Groups: Rules of Engagement

A. Vaccine Dispensing	C. Logistics	E. Comms & Outreach
B. Vaccine Dispensing	D. Logistics	F. Comms & Outreach

- Speak up – we have a diverse group of perspectives and we want to hear them all
- Utilize the chat function to add context and ask questions; be prepared to share verbally if a co-facilitator asks you to share with the group
- Refer any questions to your facilitator(s)

Observation Gallery Notes

- You will remain in this large, virtual room for the next 40 minutes, and may use the time as desired
- Breakout group questions are provided on screen for your review/consideration
- During the large group debriefs, we encourage you to ask questions and share insights

Breakout Groups – Round 2:
How to Proactively Manage Identified Risks to Executing the Plan

For the assigned focus area, each group discusses:

- What specific and timebound steps are needed to proactively manage against high priority risks?

Notes:
*Facilitators lead groups to **focus on 1 risk at a time** and get through as many high priority risks as possible in the allotted time;*
Facilitators also consistently reinforce the need for specific, time bound actions rather than generalizations

LUNCH BREAK

PLEASE RETURN AT 12:31

What specific and timebound steps should be taken to proactively manage against high priority risks?

Team E

What specific and timebound steps should be taken to proactively manage against high priority risks?

Team F

What specific and timebound steps should be taken to proactively manage against high priority risks?

Team A

What specific and timebound steps should be taken to proactively manage against high priority risks?

Team A

What specific and timebound steps should be taken to proactively manage against high priority risks?

Team B

What specific and timebound steps should be taken to proactively manage against high priority risks?

Team C

What specific and timebound steps should be taken to proactively manage against high priority risks?

Team D

NEXT STEPS

CLOSING COMMENTS

CURTIS BROWN, STATE COORDINATOR OF EMERGENCY MANAGEMENT

CLOSING COMMENTS

DR. OLIVER, STATE HEALTH COMMISSIONER

VACCINATION TTX SURVEY